STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure survey. This visit included the investigation of Complaint IN00088839 and IN00089744. Complaint IN00088839: Unsubstantiated due to lack of evidence. Complaint IN00089744: Substantiated. No deficiencies related to the allegations are cited. Survey dates: May 4, 5, and 6, 2011 Facility Number: 012263 Provider Number: 012263 AIM Number: N/A Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Rita Mullen, R.N. (5/5, 5/6) Census bed type: Residential--84 Total--84 Census payor type: Other--84 Total--84 Residential Sample: 10	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These Residential State findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 10, 2011 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0090	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request A. Based on interview and record review, the facility failed to report 2 significant injuries to the Division of Long Term Care, Indiana State Department of Health. This impacted 1 of 1 residents [Resident #72] who fell and sustained a fractured nose, and subsequently required hospitalization; and 1 of 1 residents [Resident #84] who fell and sustained a forehead laceration and required staple sutures during an emergency room visit; in a sample of 10 residents reviewed. B. Based on observation and interview, the facility failed place the results of the most recent survey in an area that was readily accessible to residents of the facility. This had the potential to affect the 84 residents living in the facility Findings include: A.1. In an interview during the initial orientation tour on 5/4/11 at 10:30 A.M., L.P.N. #2 indicated Resident #72 had facial bruising from a fall about 1 month ago. The clinical record was reviewed on	R0090	A. All unusual occurrences will be reported to the Department within 24 hours of the incident. Unusual occurrence guidelines were reviewed with all directors. All accidents/incidents will be reviewed upon event to determine whether or not it needs to be reported.The administrator or Director of Nursing will inform the Department of any unusual occurrence within 24 hours. Completion Date: OngoingB. Results of the most recent survey are accessible to residents and visitors in the front lobby. The binder was moved immediately when surveyors brought this to the facilities attention. All management was informed that binder must remain in the front lobby, accessible to residents at all times. Completion Date: 5/5/2011	05/06/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5/4/11 at 1:33 P.M. The resident was admitted to the facility's locked/secured Alzheimer's unit on 11/27/10 with diagnoses which included, but were not limited to, dementia, anemia, chronic kidney disease, and recurrent urinary tract infections. A "Nurse's Notes" progress note, dated 3/17/11 at 1:05 A.M., indicated "Found resident lying on her right side on floor between the bed and outside wall, bleeding from nose, roof of mouth, and right side scalp. Roof of mouth has two 1 x 0.5 cm [centimeter] punctures versus lacerations; difficult to access [sic] depth. Right side scalp laceration small .5 x .5 cm. Resident cleaned of blood.... bleeding stopped. Resident resting in bed, seemed stable, but bleeding again from nose and mouth. E.M.S. called at 1:05 A.M., resident left in ambulance.... resident remained alert and oriented times 2." An acute care hospital discharge summary, dated 3/21/11, listed discharge diagnoses as: comminuted fracture of the nasal bone, a non-displaced fracture of the anterior wall of the right maxilla, a left wrist contusion, and an old cervical spine odontoid process fracture. Copies of all of the incidents/accidents			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reported to the state agency by the facility since the last licensure survey were provided by the state agency for review prior to this re-licensure survey. A report related to Resident #72's fall and nasal fracture was not found. During the daily conference on 5/4/11 at 3:22 P.M., the General Manager was given the opportunity to submit a copy of the incident report related to Resident #72's fall and facial fracture. In an interview during the daily conference on 5/5/11 at 3:15 P.M., the Director of Nursing indicated the Administrator at that time [and who was no longer employed by the facility] had told her that the incident was not reportable "because the resident was not totally dependent." A.2. In an interview during the initial orientation tour on 5/4/11 at 10:40 A.M., L.P.N. #2 indicated Resident #84 had a fall 3 to 4 weeks ago, and sustained a laceration to her right forehead area. The clinical record for Resident #84 was reviewed on 5/5/11 at 1:45 P.M. The resident was admitted on 8/19/10 to the facility secured/locked Alzheimer's unit with diagnoses which included, but were not limited to, senile dementia-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	-Alzheimer's type with behavior disturbance, hypertension, and long history of electrolyte imbalance due to psychogenic polydipsia. A "Nurse's Notes" progress note, dated 3/29/11 at 3:02 A.M., indicated "At 2:05 A.M. resident found on her left side, on her bedroom floor, bleeding from right forehead, laceration approximately 2 inches by 1/4 inch, no additional injuries found..... [vital signs and neurological checks listed].... At 3:05 A.M. [name of ambulance company] transported to [name of acute care hospital] for suture." The resident returned to the facility at 6:15 A.M., with 9 staple sutures and a gauze bandage to the forehead. A progress note, dated 3/29/11 at 8:05 A.M., also indicated the resident had an abrasion to the right cheek. The "Brain/Head" C.T. scan report from the acute care hospital, dated 3/29/11 and completed during the emergency room visit, indicated "Right forehead laceration. Chronic intracranial changes...." Copies of all of the incidents/accidents reported to the state agency by the facility since the last licensure survey were provided by the state agency for review prior to this re-licensure survey. A report			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	related to Resident #84's fall and forehead laceration was not found. During the daily conference on 5/4/11 at 3:22 P.M., the General Manager was given the opportunity to submit a copy of the incident report related to Resident #84's fall and forehead laceration. In an interview during the daily conference on 5/5/11 at 3:15 P.M., the Director of Nursing indicated the Administrator at that time [and who was no longer employed by the facility] had told her that the incident was not reportable "because the resident was not totally dependent." B.1. During the Environmental tour with the Director of Environmental Services on 5/5/11 at 1:00 P.M., there was a sign in the front lobby indicating the Survey Book was available at the reception desk. The Survey Book was located behind the reception desk and could not be reached from the front of the reception desk. During an interview with Receptionist #1 on 5/5/11 at 2:30 P.M., she indicated the Survey Book was kept behind the reception desk and had to be requested.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to evaluate 4 residents who were admitted directly to the locked/secured Alzheimer's unit for appropriateness for that unit, of 7 residents reviewed who resided on that unit; and failed to evaluate falls for 5 of 5 residents who experienced multiple falls. This deficiency impacted 5 residents in a sample of 10 residents reviewed. [Residents #66, #69, #72, #83, and #84] Findings include: 1. In an interview during the initial orientation tour on 5/4/11 at 10:40 A.M., L.P.N. #2 indicated Resident #84 had fallen about 3 to 4 weeks ago, and sustained a laceration on her forehead. The nurse also indicated the resident had no behaviors and was not interviewable. The clinical record for Resident #84 was	R0214	A. An order will be obtained for all residents admitted to the Alzheimer's unit that specifically addresses the physician's approval for admission to that unit. A mini mental will be conducted on all residents for appropriateness of the Alzheimer' s unit. On the existing service plan; behaviors such as wandering, combativeness, agitation, etc are addressed. The assessment tool combined with the mini mental will serve as the proper evaluation for appropriate placement on the Alzheimer's Unit.Completion Date: 5/9/2011-OngoingPhysicians orders being obtained: Ongoing Falls were tracked and it was identified that Resident # 84 was falling from late evening to early hours of the morning. Upon medication review, on 4/6/2011 physician changed order to .25mg of Klonopin, and resident has had no falls since medication	05/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed on 5/5/11 at 1:45 P.M. The resident was admitted to the locked/secure Alzheimer's unit on 8/19/10 with diagnoses which included, but were not limited to, senile dementia--Alzheimer's type with behavior disturbance, hypertension, and long history of electrolyte imbalance due to psychogenic polydipsia. A. Original admission orders on 8/19/10 from the attending physician included an order to be admitted to the facility itself. However, an order to be admitted to the locked/secured Alzheimer's unit was not found. Following the entrance conference on 5/4/11, the General Manager provided a copy of the "Alzheimer's/Dementia Special Care Unit" disclosure form [State Form 48896] which is required to be submitted to a State agency annually. The form was dated as completed on 4/4/11. Section 2 of the form, under "Process and Criteria for Admission, Transfer, and Discharge," indicated the facility had a "formal written process for: Physician's evaluation/diagnosis; staff evaluation; family conference; appeal procedure" for admission, transfer, and discharge from the special unit.		change.Resident # 72 received physical therapy, was discharged from physical therapy and has since been discharged from the facility on 5/11/2011.Resident # 83 had been in therapy, medications changed on 4/15/2011 two medications were discontinued. Facility staff discovered that resident prefers his naps to take place in bed, instead of chair- sitting in chair was coinciding with falls. This was adjusted in his care plan. Resident currently enrolled in physical therapy. Resident #69 physical therapy has been ordered; service plan updated. Any physical therapy recommendations for adaptive equipment will be followed.B. An evaluation of specific resident falls is tracked in the incident report log. Upon review; any pattern of falls shall be documented in the resident's clinical record, and followed up on appropriately. Falls are also addressed on the current care plan. Intervention/ preventative measures will be addressed on the care plan as well as any triggers for falls. We will also be completing a fall risk assessment for all residents upon move in, and continue to address that on the care plan.Completion Date: Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Following the entrance conference on 5/4/11, the General Manager also provided the Admission packet for the locked/secured Alzheimer's unit which is provided to all residents/family/legal representative upon admission to that unit. There was no information/documentation related to the criteria used by the facility to determine if a prospective resident was appropriate for that unit. During the daily conference on 5/6/11 at 12:45 P.M., the Administrator was given the opportunity to submit any documentation/evidence related to how the facility evaluated a prospective resident for the Alzheimer's unit, and the criteria used to do so. In an interview on 5/6/11 at 1:00 P.M., the Director of Nursing indicated orders to admit a resident to the Alzheimer's unit had not been obtained. She indicated she had not been aware that an order was needed. The Director of Nursing also indicated there was no "specific" evaluation done for residents who were admitted to the Alzheimer's unit. In an interview at that time, the Administrator indicated a resident who wandered or was exit-seeking would be an appropriate candidate for the locked/secured unit. However, she did not think this was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	written down anywhere. B. Nurse's progress notes from 9/1/10 through 5/2/11 had documentation of 19 falls as follows: 9/4/10 at 5:25 A.M.--3 by 3 cm. [centimeter] red raised area mid-forehead. 9/12/10 at 9:00 A.M.--no injury found. 9/12/10 at 10:55 A.M.--3 by 3 by 2 cm. hematoma right occiput; bruises left hand. 9/12/10 at 10:35 P.M.--no injury found. 9/16/10 at 4:20 A.M.--laceration to back of head. 11/4/10 at 9:00 P.M.--no injury found. 11/14/10 at 11:00 P.M.--no injury found. 11/19/10 at 9:00 P.M.--witnessed fall to knees. No injury found. 12/27/10 at 8:00 P.M.--slipped under dining room table and hit head; no open area. 1/18/11 at 9:40 P.M.--witnessed attempt to sit in chair and missed seat. No injury found. 1/19/11 at 9:30 P.M.--no injury found. 1/22/11 at 2:25 A.M.--abrasions to right inner knee and right lower back. 1/24/11 at 8:00 P.M.--no injury found. 2/7/11 at 8:30 P.M.--no injury found. 2/20/11 at 1:30 P.M.--bruise right knee. 3/4/11 at 9:15 P.M.--no injury found. 3/14/11 at 10:00 P.M.--abrasion right side of forehead. 3/26/11 at 8:15 P.M.--abrasion right			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cheek. 3/29/11 at 2:05 A.M.--laceration to right side of forehead. The resident was transported to an acute care hospital Emergency Room and had 9 staple sutures to the laceration. An evaluation to determine a reason or cause for the recurrent falls was not found. In an interview at the final exit on 5/6/11 at 3:54 P.M., the Director of Nursing indicated she did keep track of the falls, but the documentation was in a personal note book. 2. In an interview during the initial orientation tour on 5/4/11 at 10:30 A.M., L.P.N. #2 indicated Resident #72 had facial bruising from a fall about 1 month ago. The clinical record was reviewed on 5/4/11 at 1:33 P.M. The resident was admitted to the facility's locked/secured Alzheimer's unit on 11/27/10 with diagnoses which included, but were not limited to, dementia, anemia, chronic kidney disease, and recurrent urinary tract infections. A. Original admission orders on 11/27/10 from the attending physician included an			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	order to be admitted to the facility itself. However, an order to be admitted to the locked/secured Alzheimer's unit was not found. Following the entrance conference on 5/4/11, the General Manager provided a copy of the "Alzheimer's/Dementia Special Care Unit" disclosure form [State Form 48896] which is required to be submitted to a State agency annually. The form was dated as completed on 4/4/11. Section 2 of the form, under "Process and Criteria for Admission, Transfer, and Discharge," indicated the facility had a "formal written process for: Physician's evaluation/diagnosis; staff evaluation; family conference; appeal procedure" for admission, transfer, and discharge from the special unit. Following the entrance conference on 5/4/11, the General Manager also provided the Admission packet for the locked/secured Alzheimer's unit which is provided to all residents/family/legal representative upon admission to that unit. There was no information/documentation related to the criteria used by the facility to determine if a prospective resident was appropriate for that unit.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During the daily conference on 5/6/11 at 12:45 P.M., the Administrator was given the opportunity to submit any documentation/evidence related to how the facility evaluated a prospective resident for the Alzheimer's unit, and the criteria used to do so. In an interview on 5/6/11 at 1:00 P.M., the Director of Nursing indicated orders to admit a resident to the Alzheimer's unit had not been obtained. She indicated she had not been aware that an order was needed. The Director of Nursing also indicated there was no "specific" evaluation done for residents who were admitted to the Alzheimer's unit. In an interview at that time, the Administrator indicated a resident who wandered or was exit-seeking would be an appropriate candidate for the locked/secured unit. However, she did not think this was written down anywhere. B. Nurse's progress notes from 11/27/10 through 5/3/11 had documentation of 9 falls as follows: 12/5/10 at 7:20 A.M.--resident reported she rolled out of bed. No injuries found. 12/15/10 at 10:55 A.M.--complained of back pain with negative thoracic/lumbar spine x-ray. 12/20/10 at 5:50 P.M.--no injury found.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/18/11 at 11:30 A.M.--hematoma observed to right forehead; resident did not know how it happened. 1/18/11 at 8:30 P.M.--no injury found. 3/1/11 at 6:00 P.M.--no injury found. 3/12/11 at 10:50 A.M.--no injury found. 3/17/11 at 1:05 A.M.--bleeding from nose, roof of mouth, and right side scalp. The resident was sent to an acute care hospital Emergency room. C.T. scan reports indicated the resident had sustained a comminuted fracture of the nasal bone, a non-displaced fracture of the anterior wall of the right maxilla, and a contusion of the left wrist. 4/30/11 at 8:20 A.M.--complained of back pain and was transported to an acute care hospital Emergency room for evaluation. She returned with negative findings. An evaluation to determine a reason or cause for the recurrent falls was not found. In an interview at the final exit on 5/6/11 at 3:54 P.M., the Director of Nursing indicated she did keep track of the falls, but the documentation was in a personal note book. 3. In an interview during the initial orientation tour on 5/4/11 at 10:40 A.M., L.P.N. #2 indicated Resident #83 had fallen in the facility some time ago and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sustained a fractured hip. She indicated he had gone to an Extended Care/Nursing facility for rehabilitation, and had just recently returned to this facility, but was now living in the locked/secured Alzheimer's unit. She indicated the resident's spouse continued to live in the "assisted living" part of the facility. The clinical record for Resident #83 was reviewed on 5/6/11 at 6:40 A.M. The resident was originally admitted to the facility on 3/12/10. On 12/27/10, he fell and sustained a fractured hip. Following his stay in an acute care hospital, the resident received rehabilitation in an Extended Care/Nursing Home facility from 12/30/10 to 4/7/11. He was admitted directly to the locked/secured Alzheimer's unit of this facility on 4/7/11. Diagnoses included, but were not limited to, depression, anxiety, memory loss, atrial fibrillation, osteoarthritis, hypertension, benign prostatic hypertrophy, and history of a fractured left hip. A. The resident's admission orders, dated 4/7/11, included an order to be admitted to the facility. There was no order for the resident to be admitted to the secured/locked Alzheimer's unit.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Following the entrance conference on 5/4/11, the General Manager provided a copy of the "Alzheimer's/Dementia Special Care Unit" disclosure form [State Form 48896] which is required to be submitted to a State agency annually. The form was dated as completed on 4/4/11. Section 2 of the form, under "Process and Criteria for Admission, Transfer, and Discharge," indicated the facility had a "formal written process for: Physician's evaluation/diagnosis; staff evaluation; family conference; appeal procedure" for admission, transfer, and discharge from the special unit. Following the entrance conference on 5/4/11, the General Manager also provided the Admission packet for the locked/secured Alzheimer's unit which is provided to all residents/family/legal representative upon admission to that unit. There was no information/documentation related to the criteria used by the facility to determine if a prospective resident was appropriate for that unit. During the daily conference on 5/6/11 at 12:45 P.M., the Administrator was given the opportunity to submit any documentation/evidence related to how the facility evaluated a prospective			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident for the Alzheimer's unit, and the criteria used to do so. In an interview on 5/6/11 at 1:00 P.M., the Director of Nursing indicated orders to admit a resident to the Alzheimer's unit had not been obtained. She indicated she had not been aware that an order was needed. The Director of Nursing also indicated there was no "specific" evaluation done for residents who were admitted to the Alzheimer's unit. In an interview at that time, the Administrator indicated a resident who wandered or was exit-seeking would be an appropriate candidate for the locked/secured unit. However, she did not think this was written down anywhere. B. An undated "Resident Transfer Form" from the facility that was providing rehabilitation indicated on the reverse side: "Patient has bed and chair alarms due to high risk for falls. Patient does get up unassisted." Nurse's progress notes from 4/7/11 through 5/3/11 had documentation of 7 falls as follows: 4/9/11 at 7:40 P.M.-- "... trying to get in my chair...." No injuries found. 4/10/11 at 10:30 A.M.-- "... trying to get in my recliner...." No injuries found.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4/12/11 at 7:30 P.M.-- "... trying to get up and walk to bed...." Abrasion on right knee. 4/13/11 at 2:20 P.M.--no injuries found. 4/26/11 at 4:10 P.M.-- "... trying to get out of bed by self...." No injuries found. 4/28/11 at 8:00 A.M.-- "... trying to stand up without assist...." No injuries found. 5/1/11 at 6:15 A.M.--no injuries found. An evaluation to determine a reason or cause for the recurrent falls was not found. In an interview at the final exit on 5/6/11 at 3:54 P.M., the Director of Nursing indicated she did keep track of the falls, but the documentation was in a personal note book. 4. The record of Resident #66 was reviewed on 5/5/11 at 2 P.M. Diagnoses included, but are not limited to, Alzheimer's and COPD [chronic obstructive pulmonary disease]. Resident #66 was admitted directly to the Alzheimer's unit on 1/15/11. The preadmission assessment, dated 1/15/11, did not evaluate the resident for the Alzheimer's unit prior to her being admitted.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5. Record review for Resident #69 was done on 5/5/11 at 9:20 A.M. Diagnoses included, but are not limited to, Alzheimer's disease, weight loss, wet macular degeneration, glaucoma of both eyes. Resident #69 was directly admitted to the Alzheimer's unit 6/1/10. The preadmission assessment, dated 5/26/10, did not evaluate the resident for the Alzheimer's unit prior to her being admitted. Resident #69 had falls on the following dates: 12/3/10- found on floor, no injuries. 12/9/10-fell and hit head, small lesion. Daughter took resident to the emergency room. 12/23/10- Resident found on floor by visitors, no injuries. 1/10/11- Found on floor on left side. X-rays done, no injuries. 2/4/11-found on floor at foot of bed, no injuries. 3/31/11-found on floor in room. 4 x 2 cm abrasion on right lower back. 4/29/11-found on floor ion bottom, no injuries. The preadmission service plan and her most recent service plan, dated 3/2/11, did not indicate any changes in her condition.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview with Alzheimer's Unit Manager 5/5/11 at 1:10 P.M., she indicated that when a resident has falls they would refer the person to physical therapy to see if there is anything they can do. Then they would hold a service plan meeting to address the issue. She also indicated Resident #69 had not had physical therapy. In an interview with the Administrator on 5/6/11 at 3:45 P.M., she indicated they do not have an evaluation tool in place to specifically evaluate someone for the Alzheimer's unit, prior to their admission to that unit.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to identify and document the services to be provided to 4 of 5 residents reviewed who experienced multiple falls; in a sample of 10 residents reviewed. [Residents #69, #72, #83, and #84] Findings include:	R0217	Resident # 84 was falling from late evening to early hours of the morning. Upon medication review, on 4/6/2011 physician changed order to .25mg of Klonopin, and resident has had no falls since medication change. Resident falls are addressed on the care plan. Resident #72 received physical therapy, was discharged from physical therapy and has since been discharged	05/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. In an interview during the initial orientation tour on 5/4/11 at 10:40 A.M., L.P.N. #2 indicated Resident #84 had fallen about 3 to 4 weeks ago, and sustained a laceration on her forehead. The nurse also indicated the resident had no behaviors and was not interviewable. The clinical record for Resident #84 was reviewed on 5/5/11 at 1:45 P.M. The resident was admitted to the locked/secure Alzheimer's unit on 8/19/10 with diagnoses which included, but were not limited to, senile dementia--Alzheimer's type with behavior disturbance, hypertension, and long history of electrolyte imbalance due to psychogenic polydipsia. Nurse's progress notes from 9/1/10 through 5/2/11 had documentation of 19 falls as follows: 9/4/10 at 5:25 A.M.--3 by 3 cm. [centimeter] red raised area mid-forehead. 9/12/10 at 9:00 A.M.--no injury found. 9/12/10 at 10:55 A.M.--3 by 3 by 2 cm. hematoma right occiput; bruises left hand. 9/12/10 at 10:35 P.M.--no injury found. 9/16/10 at 4:20 A.M.--laceration to back of head. 11/4/10 at 9:00 P.M.--no injury found. 11/14/10 at 11:00 P.M.--no injury found.		from the facility on 5/11/2011.Resident # 83 had been in therapy, medications changed on 4/15/2011 2 medications were discontinued. Facility staff discovered that resident prefers his naps to take place in bed, instead of chair-sitting in chair was coinciding with falls. This was adjusted in his care plan. Resident currently enrolled in physical therapy.Resident #69 physical therapy has been ordered; service plan updated. Any physical therapy recommendations for adaptive equipment will be followed. An evaluation of specific resident falls is tracked in the incident report log, upon review; any pattern of falls shall be documented in the resident's clinical record, and followed up on appropriately. Falls are also addressed on the current care plan. Intervention/ preventative measures will be addressed on the care plan as well as any triggers for falls. We will also be completing a fall risk assessment for all residents upon move in. The facility added a section to the care plan that will also address falls. Completion Date: Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	11/19/10 at 9:00 P.M.--witnessed fall to knees. No injury found. 12/27/10 at 8:00 P.M.--slipped under dining room table and hit head; no open area. 1/18/11 at 9:40 P.M.--witnessed attempt to sit in chair and missed seat. No injury found. 1/19/11 at 9:30 P.M.--no injury found. 1/22/11 at 2:25 A.M.--abrasions to right inner knee and right lower back. 1/24/11 at 8:00 P.M.--no injury found. 2/7/11 at 8:30 P.M.--no injury found. 2/20/11 at 1:30 P.M.--bruise right knee. 3/4/11 at 9:15 P.M.--no injury found. 3/14/11 at 10:00 P.M.--abrasion right side of forehead. 3/26/11 at 8:15 P.M.--abrasion right cheek. 3/29/11 at 2:05 A.M.--laceration to right side of forehead. The resident was transported to an acute care hospital Emergency Room and had 9 staple sutures to the laceration. An "Assessment and Service Plan for Indiana Assisted Living Facilities" form, dated as completed on 2/17/11, indicated in the "Mobility" section: "Resident independent with ambulation, but gait unsteady." There was no section related to or addressing the resident's falls, listing the services to be provided			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	by the facility. During the daily conference on 5/5/11 at 3:00 P.M., the Director of Nursing was given the opportunity to submit any documentation/evidence related to services to be provided by the facility that addressed the resident's falls. In an interview during the daily conference on 5/6/11 at 12:45 P.M., the Administrator indicated the current Service Plan form being used did not have a section designated specifically to address falls. 2. In an interview during the initial orientation tour on 5/4/11 at 10:30 A.M., L.P.N. #2 indicated Resident #72 had facial bruising from a fall about 1 month ago. The clinical record was reviewed on 5/4/11 at 1:33 P.M. The resident was admitted to the facility's locked/secured Alzheimer's unit on 11/27/10 with diagnoses which included, but were not limited to, dementia, anemia, chronic kidney disease, and recurrent urinary tract infections. Nurse's progress notes from 11/27/10 through 5/3/11 had documentation of 9 falls as follows: 12/5/10 at 7:20 A.M.--resident reported she rolled out of bed. No injuries found. 12/15/10 at 10:55 A.M.--complained of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	back pain with negative thoracic/lumbar spine x-ray. 12/20/10 at 5:50 P.M.--no injury found. 1/18/11 at 11:30 A.M.--hematoma observed to right forehead; resident did not know how it happened. 1/18/11 at 8:30 P.M.--no injury found. 3/1/11 at 6:00 P.M.--no injury found. 3/12/11 at 10:50 A.M.--no injury found. 3/17/11 at 1:05 A.M.--bleeding from nose, roof of mouth, and right side scalp. The resident was sent to an acute care hospital Emergency room. C.T. scan reports indicated the resident had sustained a comminuted fracture of the nasal bone, a non-displaced fracture of the anterior wall of the right maxilla, and a contusion of the left wrist. 4/30/11 at 8:20 A.M.--complained of back pain and was transported to an acute care hospital Emergency room for evaluation. She returned with negative findings. An "Assessment and Service Plan for Indiana Assisted Living Facilities" form, dated as completed on "2/11," indicated in the "Mobility" section: "Resident independent with ambulation use walker." There was no section related to or addressing the resident's falls or listing the services to be provided by the facility. During the daily conference on 5/5/11 at 3:00 P.M., the Director of Nursing was given the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	opportunity to submit any documentation/evidence related to services to be provided by the facility that addressed the resident's falls. In an interview during the daily conference on 5/6/11 at 12:45 P.M., the Administrator indicated the current Service Plan form being used did not have a section designated specifically to address falls. 3. In an interview during the initial orientation tour on 5/4/11 at 10:40 A.M., L.P.N. #2 indicated Resident #83 had fallen in the facility some time ago and sustained a fractured hip. She indicated he had gone to an Extended Care/Nursing facility for rehabilitation, and had just recently returned to this facility, but was now living in the locked/secured Alzheimer's unit. The clinical record for Resident #83 was reviewed on 5/6/11 at 6:40 A.M. The resident was originally admitted to the facility on 3/12/10. On 12/27/10, he fell and sustained a fractured hip. Following his stay in an acute care hospital, the resident received rehabilitation in an Extended Care/Nursing Home facility from 12/30/10 to 4/7/11. He was admitted directly to the locked/secured Alzheimer's unit of this facility on 4/7/11. Diagnoses included, but were not limited to, depression, anxiety, memory loss,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	atrial fibrillation, osteoarthritis, hypertension, benign prostatic hypertrophy, and history of a fractured left hip. An undated "Resident Transfer Form" from the facility that was providing rehabilitation indicated on the reverse side: " Patient has bed and chair alarms due to high risk for falls. Patient does get up unassisted." Nurse's progress notes from 4/7/11 through 5/3/11 had documentation of 7 falls as follows: 4/9/11 at 7:40 P.M.-- "... trying to get in my chair...." No injuries found. 4/10/11 at 10:30 A.M.-- "... trying to get in my recliner...." No injuries found. 4/12/11 at 7:30 P.M.-- "... trying to get up and walk to bed...." Abrasion on right knee. 4/13/11 at 2:20 P.M.--no injuries found. 4/26/11 at 4:10 P.M.-- "... trying to get out of bed by self...." No injuries found. 4/28/11 at 8:00 A.M.-- "... trying to stand up without assist...." No injuries found. 5/1/11 at 6:15 A.M.--no injuries found. An "Assessment and Service Plan for Indiana Assisted Living Facilities" form, dated as completed on 4/5/11 as a " Pre-Admission " assessment and service			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plan, indicated in the "Mobility" section: "Requires escort to all meals. Uses wheelchair." The " Transferring " section indicated: " Requires assistance with all transfers. " There was no section related to or addressing the resident's falls or listing the services to be provided by the facility. During the daily conference on 5/5/11 at 3:00 P.M., the Director of Nursing was given the opportunity to submit any documentation/evidence related to services to be provided by the facility that addressed the resident's falls. In an interview during the daily conference on 5/6/11 at 12:45 P.M., the Administrator indicated the current Service Plan form being used did not have a section designated specifically to address falls. 4. The record of Resident #69 was reviewed on 5/5/11 at 9:20 A.M. Diagnoses included, but are not limited to, Alzheimer's disease, weight loss, wet macular degeneration, glaucoma of both eyes. Resident #69 had falls on the following dates: 12/3/10- found on floor, no injuries. 12/9/10-fell and hit head, small lesion. Daughter took resident to the emergency room.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12/23/10- Resident found on floor by visitors, no injuries. 1/10/11- Found on floor on left side. X-rays done, no injuries. 2/4/11-found on floor at foot of bed, no injuries. 3/31/11-found on floor in room. 4 x 2 cm abrasion on right lower back. 4/29/11-found on floor ion bottom, no injuries. The preadmission service plan did not indicate any concerns related to falls. The 90 day/Quarterly assessment service plan, dated 3/2/11, did not indicate any changes in her condition. The service plan had no interventions in place for prevention of falls. In an interview with Alzheimer's Unit Manager 5/5/11 at 1:10 P.M., she indicated that when a resident has falls they would refer the person to physical therapy to see if there is anything they can do. Then they would hold a service plan meeting to address the issue. She also indicated Resident #69 had not had physical therapy.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS, LLC	11755 NORTH MICHIGAN ROAD ZIONSVILLE, IN46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0273	(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure that the dry storage goods were dated and covered. This deficient practice had the potential to affect all 84 residents in the facility. Findings include: The tour of the kitchen began on 5/4/11 at 9:20 A.M. In the dry storage area on the shelf there was one plastic container full of cereal, one bag of corn meal, and one bag of pinto beans that had no date on it. There was one paper bag of kidney beans opened to the air and not dated. During the tour of the kitchen on 5/4/11 at 9:30 A.M., the Kitchen Manager indicated those items must have gotten missed as most of the items in the dry storage area have dates on them. He also indicated that typically the kidney beans would be put into a plastic container after being opened.	R0273	A. All food discovered on the tour with the department that was not labeled, covered or stored appropriately was immediately discarded. The Food Service Director immediately in-service all food service staff on the proper storage and labeling of dry food and refrigerated items. The food service director will monitor on a daily basis and ensure compliance. Completion Date: 5/4/2011	05/06/2011